Quality Payment
PROGRAM

MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS) 101 GUIDE

2019 Performance Year

Updated 4/27/2020

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*CMS is implementing multiple flexibilities to provide relief to clinicians responding to the 2019 Novel Coronavirus (COVID-19) pandemic. Refer to the **Quality Payment Program COVID-19 Response Fact Sheet** for more information.*

HOW TO USE THIS GUIDE

Please Note: This guide was prepared for informational purposes only and is not intended to grant rights or impose obligations. The information provided is only intended to be a general summary. It is not intended to take the place of the written law, including the regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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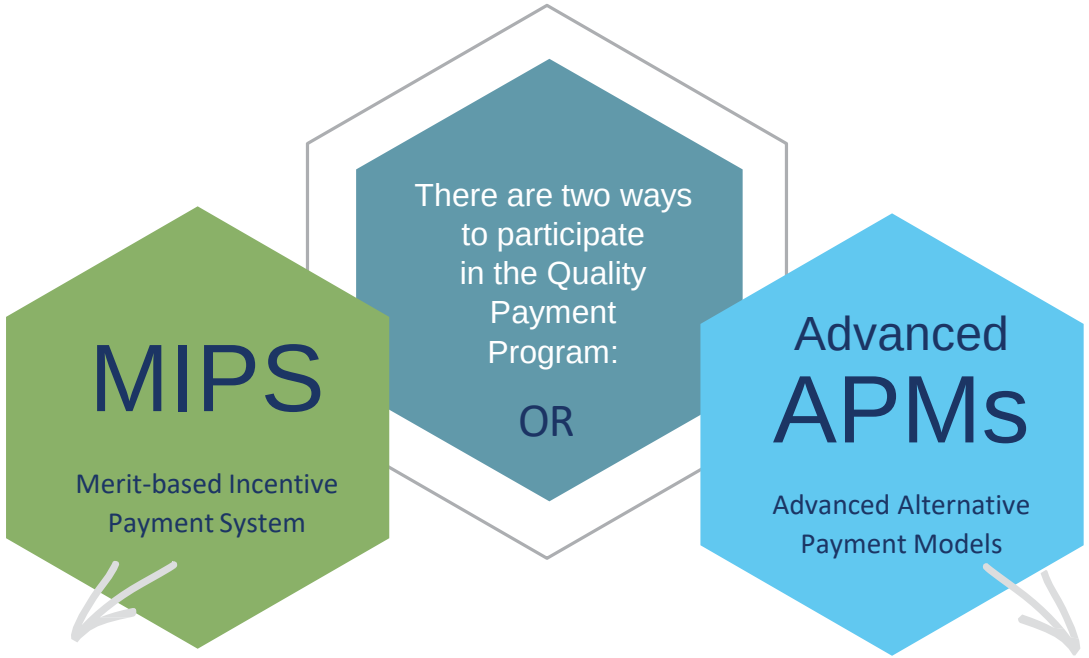
Hyperlinks

Hyperlinks to the QPP website are included throughout the guide to direct the reader to more information and resources.

INTRODUCTION TO THE QUALITY PAYMENT PROGRAM

What is the Quality Payment Program?

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) ended the Sustainable Growth Rate (SGR) formula, which would have resulted in a significant cut to payment rates for clinicians participating in Medicare. By law, MACRA requires CMS to implement an incentive program, referred to as the Quality Payment Program, which provides two participation tracks for clinicians:



If you are a MIPS eligible clinician, you will be subject to a performance-based payment adjustment through MIPS.

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for sufficiently participating in an innovative payment model.

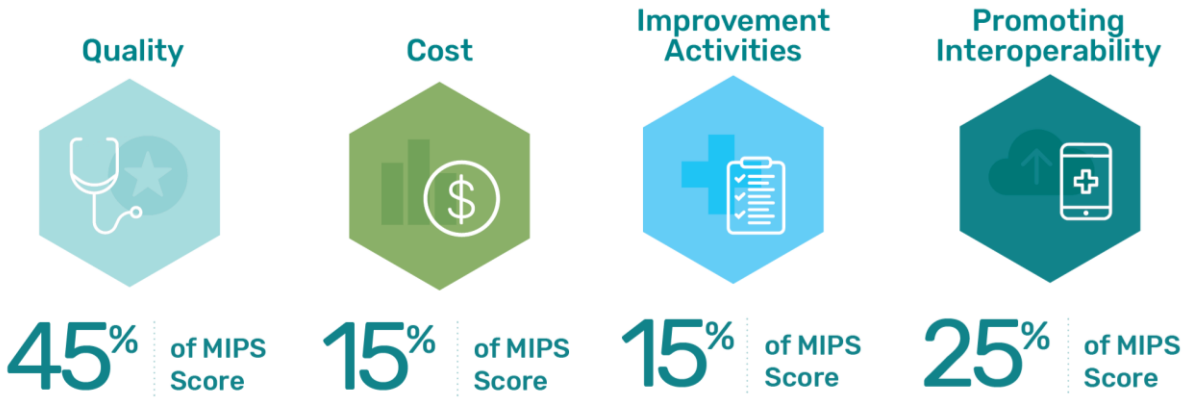
This guide provides an overview of the MIPS track. You can find more information on how to participate in APMs at https://qpp.cms.gov/apms/overview.

MIPS OVERVIEW

What is the Merit-based Incentive Payment System (MIPS)?

Under MIPS, there are 4 performance categories that could affect your future Medicare payments. Each performance category is scored by itself and has a specific weight that is part of the MIPS Final Score. The payment adjustment determined for each MIPS eligible clinician is based on the Final Score. These are the performance category weights for the 2019 MIPS Performance Year:

MIPS performance category weights in 2019:



Please note that for MIPS APM participants, scored under the APM scoring standard, the performance categories have the following weights:

50% Quality | 0% Cost | 20% Improvement Activities | 30% Promoting Interoperability

To learn more about how to participate in MIPS:

- *Visit the MIPS Eligibility and Individual or Group Participation web pages on the Quality Payment Program website.*
- *View the 2019 MIPS Participation and Eligibility Fact Sheet.*
- *Check your current participation status using the QPP Participation Status Tool.*

When Does the 2019 MIPS Performance Period Start?

If you're participating in MIPS in 2019, also referred to as Year 3, the performance period starts January 1, 2019 and ends on December 31, 2019.

Below are some key dates for Year 3 participation:

Jan. 1, 2019	Jan. 2019	Oct. 3, 2019	Nov./Dec. 2019	Dec. 31, 2019	Jan. 2, 2020 – March 31, 2020	July 2020	Jan. 1, 2021 – Dec. 31, 2021
2019 MIPS performance period begins	Preliminary 2019 MIPS eligibility is available	The last day to begin data collection for a continuous 90-day performance period for the Improvement Activities and/or Promoting Interoperability performance categories	Final 2019 MIPS eligibility is available (for non-APM participants)	• 2019 MIPS performance period ends • Deadline for submitting a Promoting Interoperability Hardship Exception Application • Deadline for submitting a Quality Payment Program Extreme and Uncontrollable Circumstance Exception Application (available for all performance categories)	2019 MIPS performance period data submission window	2019 MIPS final score and performance feedback available	2021 Payment adjustments based on 2019 MIPS performance period performance are applied to payments made for Part B covered professional services payable under the Physician Fee Schedule

PARTICIPATING IN MIPS IN 2019

What Types of Clinicians are Included in MIPS for the 2019 Performance Year?

For the 2019 performance year, you are a MIPS eligible clinician if you are one of the following clinician types:

- Physicians *(including doctors of medicine, osteopathy, dental surgery, dental medicine, podiatric medicine, and optometry; osteopathic practitioners; and chiropractors[1])*
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- NEW — Clinical Psychologists
- NEW — Physical Therapists
- NEW — Occupational Therapists
- NEW — Qualified Speech-Language Pathologists
- NEW — Qualified Audiologists
- NEW — Registered Dietitians or Nutritional Professionals
- Groups or virtual groups that include 1 or more of these MIPS eligible clinician types

[1]With respect to certain specified treatment, a Doctor of Chiropractic legally authorized to practice by a State in which he/she performs this function.

Who is Required to Participate in MIPS for the 2019 Performance Year?

If you're one of the clinician types listed on the previous page, you are required to participate in MIPS if you:

Exceed the low-volume threshold **AND** Enrolled in Medicare prior to January 1, 2019 **AND** Don't become a QP or Partial QP

Who is Excluded from MIPS?

If you are a MIPS eligible clinician type (as indicated by the clinician types on the previous page), you can still be excluded from participating in MIPS for the 2019 performance year if you:

Enrolled in Medicare for the first time in 2019 **OR** Participate in an Advanced APM and are determined to be a Qualifying APM Participant (QP) **OR** Participate in an Advanced APM and are determined to be a Partial QP and do not elect to participate in MIPS **OR** Don't become a QP or Partial Q

If you're not a MIPS eligible clinician or are otherwise excluded from MIPS in 2019, you do not have to participate in MIPS for the 2019 performance year and you will not receive a MIPS payment adjustment in 2021.

Low-Volume Threshold for 2019

We look at your Medicare claims from two 12-month segments, referred to as the MIPS determination period, to assess the volume of care you provide to Medicare beneficiaries. The two 12-month segments used to assess eligibility for the 2019 MIPS performance year are:

October 1, 2017 – September 30, 2018 **AND** October 1, 2018 – September 30, 2019

NOTE: You must exceed the low-volume threshold during both segments to be eligible for MIPS. If you join a new practice after September 30, 2018 and assign your billing rights to a new or different TIN, your eligibility will be evaluated under that new practice during the second segment of the MIPS determination period.

For the 2019 performance year, we added a third element—Number of Services—to the low-volume threshold determination criteria. The other two low-volume threshold elements are the same as Year 2 (2018). Clinicians, groups, and MIPS APM entities are excluded from MIPS if, during either segment of the MIPS determination period they:

Billed Medicare for less than or equal to $90,000 in Medicare Part B allowed charges for covered professional services payable under the Medicare Physician Fee Schedule (PFS)

OR

Provided care for 200 or fewer Part B-enrolled Medicare FFS beneficiaries

OR

Provided 200 or fewer covered professional services under the PFS

The low-volume threshold is calculated at both the practice (TIN) level and clinician (TIN/NPI) level. MIPS eligible clinicians who have reassigned billing rights to multiple practices will be evaluated against the low-volume threshold at each practice (under each TIN/NPI combination), which means you may be required to participate in MIPS at one practice but are excluded at another.

Low-Volume Threshold for 2019 *(continued)*

The low-volume threshold exclusion is calculated and applied:

If you participate in MIPS as an individual (meaning you will submit your own individual data collected at the practice), the low-volume threshold exclusion is applied to you as an individual clinician.

- A clinician who does not exceed the low-volume threshold as an individual is not considered MIPS eligible for individual participation at this practice, is not required to submit individual data collected at this practice, and will not receive a payment adjustment at this practice based on any individual submission.

If your practice intends to participate in MIPS as a group (meaning the practice will submit aggregated data collected on behalf of all the clinicians in the practice), the low-volume threshold exclusion is applied to the group as a whole.

- A practice that does not exceed the low-volume threshold at the group level is not considered MIPS eligible and clinicians in the group will not receive a payment adjustment.
- A practice that exceeds the low-volume threshold at the group level can choose to submit aggregated group-level data. The MIPS eligible clinicians in the group (which, for group participation, includes those who do not exceed the low-volume threshold as individuals) will receive a payment adjustment at this practice based on the group's submission. If a practice participates in MIPS at the group level, the low-volume threshold determination for clinicians at the individual level is not applicable.

For more information on the low-volume threshold and the determination period, please refer to the 2019 MIPS Participation and Eligibility Fact Sheet.

Low-Volume Threshold for 2019 *(continued)*

If you (solo practitioner) or your practice were approved to participate in MIPS as part of a virtual group (meaning the virtual group will submit aggregated data collected on behalf of all the clinicians in the virtual group), you (as a solo practitioner) would have exceeded the low-volume threshold at the individual level or your practice would have exceeded the low-volume threshold at the group level in order to be approved to participate in MIPS as a virtual group.

- MIPS eligible clinicians participating in an approved virtual group will receive a payment adjustment based on the virtual group's submission of data.

If you participate in a MIPS APM and will be scored under the APM scoring standard, the low-volume threshold is applied to the APM Entity as a whole.

- Eligible clinicians in an APM Entity that does not exceed the low-volume threshold are not considered MIPS eligible and clinicians in the Entity will not receive a payment adjustment.
- An APM entity (with clinicians scored under the APM scoring standard) that exceeds the low-volume is required to participate in MIPS. The MIPS eligible clinicians in the APM entity (which, for MIPS APM participation, includes those who do not exceed the low-volume threshold at the individual or group level) will receive a payment adjustment based on the final score received under the APM scoring standard. For an APM Entity participating in MIPS, the low-volume threshold determination for clinicians at the individual or group level is not applicable.
- MIPS eligible clinicians participating in a MIPS APM should work with their MIPS APM Entity to understand their data submission requirements.

For more information on the low-volume threshold and the determination period, please refer to the 2019 MIPS Participation and Eligibility Fact Sheet.

New for 2019: What is the Opt-in Policy?

The opt-in policy allows some clinicians who would otherwise be excluded from MIPS the opportunity to participate and earn a payment adjustment.

Who can opt in?

MIPS eligible clinicians, groups, and APM entities can elect to opt-in to MIPS if they exceed one or two, but not all three, elements of the low-volume threshold.

Low-volume Threshold

Clinicians and groups are evaluated against the low-volume threshold in two 12-month segments called the MIPS Determination Period

Not Eligible to Opt-in

Clinicians and groups that do not exceed any elements of the low-volume threshold in either segment of the MIPS Determination Period are not eligible to opt-in

If an individual, group, and/or MIPS APM Entity elects to opt-in, they will:

MIPS Eligible if not excluded

Be considered MIPS eligible clinicians if they are not otherwise excluded

MIPS Payment Adjustment

Receive a MIPS payment adjustment

AND

Physician Compare

Be eligible to have their data published on Physician Compare

Same as Other Participants

Be assessed in the same way as MIPS eligible clinicians who are required to participate in MIPS and are therefore automatically included

If you don't exceed any of the three low-volume threshold criteria, you can voluntarily report but are not able to opt-in. If you choose to voluntarily report, you will not receive a payment adjustment in 2021

TIP: The decision to opt-in to MIPS is irreversible. If you are considering this option, be sure to explore program requirements, measures, and activities to ensure these are applicable to you/your group.

For more information on the low-volume threshold and the MIPS determination period, please refer to the 2019 MIPS Participation and Eligibility Fact Sheet. For information specific to the new opt-in policy, refer to the 2019 MIPS Opt-In and Voluntary Reporting Policy Fact Sheet.

What is the 2019 MIPS Voluntary Reporting Policy?

Certain clinicians can choose to voluntarily report MIPS measures and activities:

Those who are excluded from MIPS

OR

Those not required to participate in MIPS

If a clinician or group chooses to voluntarily report and bills Medicare Part B claims in the 2nd segment of the MIPS determination period, they will receive performance feedback, allowing them to prepare for future years. However, they will not receive a payment adjustment based on the data submitted.

Please note that if an individual clinician or group has the option to either elect to opt-in to MIPS or voluntarily report but chooses to do nothing, then they will continue to be excluded from MIPS and will not receive a MIPS payment adjustment.

Virtual groups, TINs participating in a virtual group, and MIPS APM Entities cannot voluntarily report for MIPS.

For more information, refer to the 2019 MIPS Opt-In and Voluntary Reporting Policy Fact Sheet.

What are Special Status Designations?

For 2019, you can receive a “special status” designation if you are practicing in a Health Professional Shortage Area (HPSA), rural practice, or small practice, or if you’re non-patient facing, hospital-based, or Ambulatory Surgical Center (ASC)-based.

If you receive a special status designation, it doesn’t mean you’re exempt from participating in MIPS. A special status designation affects the total number of measures, activities, or entire categories that you, your group, or your virtual group must submit to CMS. Specific details are outlined in the table below.

Special Status	Quality	Cost	Improvement Activities	Promoting Interoperability
Health Professional Shortage Area (HPSA)	No impact	No impact	Double points on each activity submitted: • 40 points for high-weighted activities • 20 points for medium weighted activities	No impact
Rural practice	No impact	No impact	Double points on each activity submitted: • 40 points for high-weighted activities • 20 points for medium weighted activities	No impact
Small practice	6 bonus points for clinicians who submit at least 1 measure, either individually, or as a group or virtual group	No impact	Double points on each activity submitted: • 40 points for high-weighted activities • 20 points for medium weighted activities	You can apply to have this performance category reweighted to 0% through a hardship exception application; the 25% weight would generally be reallocated to the Quality performance category

What are Special Status Designations? *(continued)*

Special Status	Quality	Cost	Improvement Activities	Promoting Interoperability
Non-patient facing	No impact	No impact	Double points on each activity submitted: • 40 points for high-weighted activities • 20 points for medium weighted activities	Reweighted to 0% of the MIPS final score; 25% weight would generally be reallocated to the Quality performance category
Hospital-based	No impact	No impact	No impact	Reweighted to 0% of the MIPS final score; 25% weight would generally be reallocated to the Quality performance category
Ambulatory Surgical Center (ASC)-based	No impact	No impact	No impact	Reweighted to 0% of the MIPS final score; 25% weight would generally be reallocated to the Quality performance category

How is Special Status Determined?

To determine if a MIPS eligible clinician, group or virtual group qualifies for a special status designation under the Quality Payment Program, CMS retrieves and analyzes your Medicare Part B claims data.

The tables on the next few pages describe how special statuses are determined and designated at the individual clinician (TIN/NPI) level, group (TIN) level, and virtual group level.

Special Status Designations

Special Status	Description
Small practice	**INDIVIDUAL:** A clinician associated with a practice that has 15 or fewer clinicians (NPIs) billing under the practice (TIN) during one of the 12-month segments of the MIPS determination period.
	GROUP: A group with 15 or fewer clinicians (NPIs) billing under the group's TIN during one or both of the 12-month segments of the MIPS determination period.
	VIRTUAL GROUP: A virtual group is considered a small practice if it has 15 or fewer clinicians (NPIs) as a collective entity during the small practice size determination period (October 1, 2017 through September 30, 2018 with a 30-day claims run out or October 1, 2018 through September 30, 2019).
Non-patient facing	**INDIVIDUAL:** The clinician has 100 or fewer Medicare Part B patient-facing encounters (including telehealth services) during one or both of the 12-month segments of the MIPS determination period.
	GROUP: A group with more than 75% of the clinicians (NPIs) billing under the group's TIN meet the definition of a non-patient facing individual MIPS eligible clinician during one or both of the 12-month segments of the MIPS determination period.
	VIRTUAL GROUP: A virtual group is considered non-patient facing if more than 75% of the clinicians billing within a virtual group meet the definition of a non-patient facing individual MIPS eligible clinician during one of the segments of the 24-month non-patient facing review periods (either October 1, 2017 through September 30, 2018 or October 1, 2018 through September 30, 2019).
Health Professional Shortage Area (HPSA)	**INDIVIDUAL:** The clinician is associated with a practice that is in an area designated as a Health Professional Shortage Area (HPSA).
	GROUP: A group in a Health Professional Shortage Area (HPSA) and with multiple practices under its TIN will be designated as an HPSA practice if more than 75% of the NPIs billing under the group's TIN are designated as an HPSA.
	VIRTUAL GROUP: A virtual group that is in an area designated under section 332(a)(1)(A) of the Public Health Service Act. A virtual group with multiple practices under its TINs within the virtual group will be designated as an HPSA practice if more than 75% of the NPIs billing within the virtual group are designated as an HSPA.

Special Status Designations

Special Status	Description
Rural	**INDIVIDUAL:** The clinician is associated with a practice that is in a zip code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data.
	GROUP: A group in a zip code designated as rural, using the most recent HRSA Area Health Resource File data, and that has multiple practices under its TIN, with more than 75% of the clinicians billing under the group's TIN in a zip code designated as rural.
	VIRTUAL GROUP: A virtual group that is in a zip code designated as rural, using the most recent Health Resources and Services Administration (HRSA) Area Health Resource File data. A virtual group with multiple practices under its TINs within the virtual group will be designated as a rural practice if more than 75% of the NPIs billing within the virtual group are designated in a zip code as a rural area.
Hospital-based	**INDIVIDUAL:** The clinician furnishes 75% or more of covered professional services in a hospital setting during one or both of the 12-month segments of the MIPS determination period. CMS determines whether a service is hospital-based by analyzing standard claims transactions or use Place of Service (POS) codes for: • Off-campus outpatient hospital (POS 19) • Inpatient hospital (POS 21) • On-campus outpatient hospital (POS 22) • Emergency room (POS 23)
	GROUP: 100% of MIPS eligible clinicians associated with the group are designated as hospital-based during one or both of the 12-month segments of the MIPS determination period. If any MIPS eligible clinician in the group does not meet the individual hospital-based criteria, the group will not be designated as hospital-based. Note: This group level calculation is limited to MIPS eligible clinicians.
	VIRTUAL GROUP: 100% of the MIPS eligible clinicians associated with the virtual group are designated as hospital-based during one or both of the 12-month segments of the MIPS determination period (October 1, 2017 through September 30, 2018 or October 1, 2018 through September 30, 2019). If any MIPS eligible clinician within the virtual group does not meet the individual hospital-based criteria, the virtual group will not be designated as hospital-based. **Note**: This virtual group level calculation is limited to MIPS eligible clinicians who are not new Medicare-enrolled eligible clinicians, and do not have a QP status.

Special Status Designations

Special Status	Description
Ambulatory Surgical Center (ASC-based)	**INDIVIDUAL:** The clinician furnishes 75% or more of covered professional services in sites of service identified by the POS code 24 in standard claims transactions during one or both of the 12-month segments of the MIPS determination period.
	GROUP: 100% of MIPS eligible clinicians associated with the group are designated as ASC-based during one or both of the 12-month segments of the MIPS determination period. If any MIPS eligible clinician in the group does not meet the individual ASC-based criteria, the group will not be designated as ASC-based. **Note:** This group level calculation is limited to MIPS eligible clinicians.
	VIRTUAL GROUP: 100% of the MIPS eligible clinicians associated with the virtual group are designated as ASC-based during one or both of the 12-month segments of the MIPS determination period (October 1, 2017 through September 30, 2018 or October 1, 2018 through September 30, 2019). If any MIPS eligible clinician with the virtual group does not meet the individual ASC-based criteria, the virtual group will not be designated as ASC-based. **Note:** This virtual group level calculation is limited to MIPS eligible clinicians who are not new Medicare-enrolled eligible clinicians, and do not have a QP status.

NOTE: Clinicians who have reassigned their billing rights to multiple practices (TINs) will be evaluated for special status designations at each practice (i.e., all TIN-NPI combinations associated with a single clinician will be evaluated to determine if each is eligible for a special status designation(s)).

Quality Payment Program Exceptions

In addition to reweighting of the Promoting Interoperability performance category because of a special status designation, there are two types of exceptions that could result in the reweighting of certain performance categories for MIPS eligible clinicians, groups, and virtual groups:

- **Promoting Interoperability Hardship Exception**
  - Refer to the Promoting Interoperability performance category section of this guide for more information.
- **Extreme and Uncontrollable Circumstances Exception**
  - MIPS eligible clinicians, groups, and virtual groups may submit an application for re-weighting of any or all MIPS performance categories if they've been impacted by extreme and uncontrollable circumstances that extend beyond the Promoting Interoperability performance category.
  - Extreme and uncontrollable circumstances are defined as rare events entirely outside of your control and the control of the facility in which you practice. These circumstances would cause you to either be:

Unable to collect information necessary to submit for a performance category

OR

Unable to submit information that would be used to score a performance category for an extended period of time (for example, if you were unable to collect data for the Quality performance category for 3 months)

Facility-Based Scoring

NEW: Beginning with the 2019 performance year, clinicians, groups, and virtual groups will be able to use their facility-based scores from the Hospital Value Based Purchasing (HVBP) Program as an alternate scoring mechanism for the Quality and Cost performance categories.

Specifically, for the 2019 MIPS performance year, we will calculate the Quality and Cost performance category scores for facility-based clinicians, groups, and virtual groups based on the Total Performance Score (TPS) calculated under the Hospital VBP Program during FY 2020.

For the 2019 MIPS performance year, the determination period for facility-based measurement is based on Medicare Part B claims billed by clinicians between October 1, 2017 and September 30, 2018 (including a 30-day claims run out).

For more information, review the 2019 Facility-based Measurement Fact Sheet and 2019 Facility-based Preview FAQs.

Facility-Based Scoring *(continued)*

You will be identified as facility-based on the QPP Participation Status Tool if you are a MIPS eligible clinician type and meet all of the following criteria:

1. You billed at least 75 percent of your covered professional services in a hospital setting.
For individual MIPS eligible clinicians that submitted covered professional service claims during the determination period using the same Taxpayer Identification Number (TIN) National Provider Identifier (NPI) combination, at least 75 percent of claims were billed at places of service indicating a hospital setting: (1) inpatient hospital (POS = 21); (2) on-campus outpatient hospital (POS= 22); or (3) emergency room (POS=23).
2. You billed at least 1 service in an inpatient hospital or emergency room.
For individual MIPS eligible clinicians who exceed the 75 percent threshold in criterion 1 using the same TIN/NPI combination, at least 1 claim billed during the determination period is at an inpatient hospital (POS = 21) or emergency room (POS=23).
3. You are attributed to a facility with a FY 2020 Hospital VBP score.
We attribute individual MIPS eligible clinicians to a hospital in which they provided services to the greatest number of Medicare beneficiaries during the determination period using the same TIN/NPI combination. Therefore, a MIPS eligible clinician that only provided services to Medicare beneficiaries at one hospital would be attributed to that hospital. A Hospital VBP score at the attributed hospital must exist to consider the TIN-NPI as facility-based. In instances where an individual MIPS eligible clinician treated an equal number of Medicare beneficiaries at more than one hospital, we will attribute the individual MIPS eligible clinician to the hospital with the highest performance score. We will also identify facility-based groups and virtual groups, in which 75 percent or more of the MIPS eligible clinicians (as identified by their individual NPIs) in a group (NPIs billing under the group's TIN) or virtual group are deemed facility-based. We will attribute clinicians in groups and virtual groups to the hospital at which the plurality of clinicians in the group or virtual group were attributed as individuals.

Participating in MIPS APMs

If you're in a specific type of APM called a MIPS APM, you will participate in MIPS through that APM and be scored using what is called the "APM scoring standard."

This APM scoring standard:

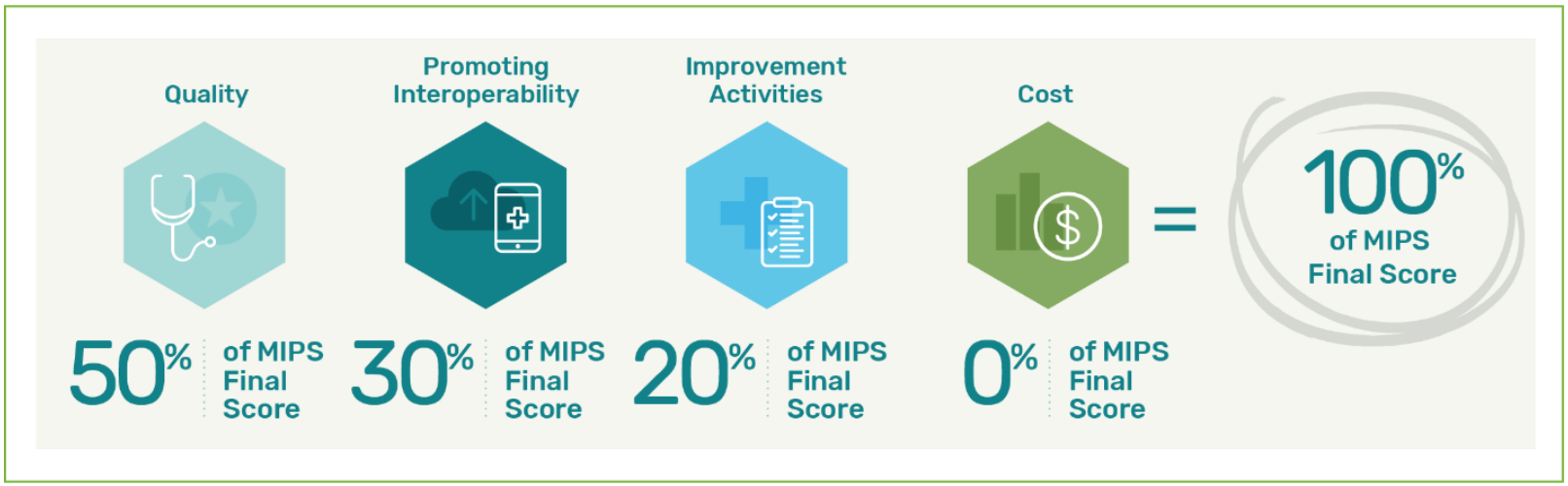
- Is designed to account for activities already required by the APM; and
- Eliminates the need for MIPS eligible clinicians to duplicate the submission of certain quality and improvement activities data.

Is designed to account for activities already required by the APM

AND

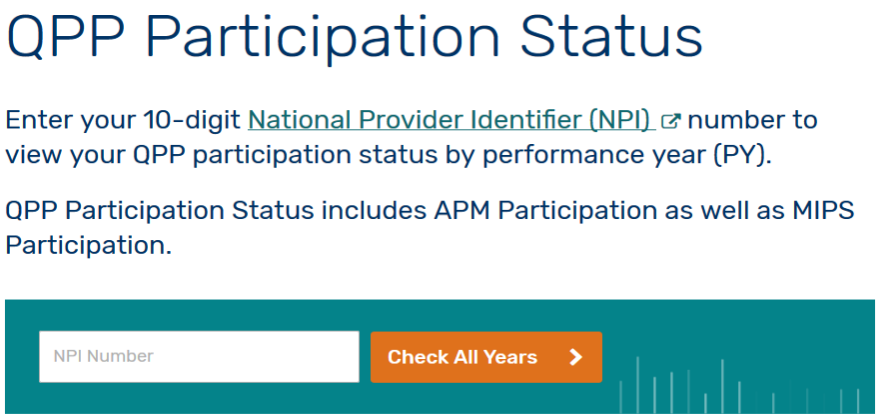
Eliminates the need for MIPS eligible clinicians to duplicate the submission of certain quality and improvement activities data

2019 weights for the APM scoring standard are as follows:



How Can I Check if I am Eligible to Participate in MIPS in 2019?

To check if you're eligible to participate in 2019, you can use the QPP Participation Status Tool on qpp.cms.gov. You can also sign in to view more detailed information for the clinicians in your organization. Just enter your 10-digit NPI.



This tool:

- Reflects eligibility based on clinician type and Medicare enrollment date.
- Includes a clinician's MIPS eligibility determination for each practice association based on low-volume threshold calculations, as well as information about special status designations, such as being hospital-based.
- Currently displays *preliminary* 2019 eligibility from the first review period (claims data from October 1, 2017 - September 30, 2018).

Later in 2019, CMS will review PECOS and Medicare Part B claims data from October 1, 2018 to September 30, 2019, and update the tool to reflect your *final* 2019 MIPS eligibility status. **NOTE:** If a MIPS eligible clinician joins a new practice between October 1, 2018 and September 30, 2019, he or she may become individually eligible for MIPS based on the second low-volume threshold analysis of claims submitted under that new TIN/NPI combination.

The QPP participation look up tool relies on claims data as well as information available in PECOS.

Can I Check MIPS Eligibility at the Group level?

To check if your group is eligible to participate in MIPS in 2019:

- Sign in to the CMS Quality Payment Program website with your user ID and password. Don't have an account? Check out the QPP Access User Guide.
- Select your group. (You can view eligibility information for all the groups for which you've requested and been granted access.)
- Access the Eligibility screen to view your practice's status at the group level and for every clinician associated with your practice through Part B claims.

You can also now download the list of all NPIs associated with your TIN. The downloaded file includes eligibility information for each NPI. **New for 2019:** Shared Savings Program ACOs, Next Generation ACOs, and Comprehensive Primary Care Plus (CPC+) practices can now download a list of NPIs associated with their entity.

Can I Participate as an Individual and a Group?

Yes. MIPS eligible clinicians can submit data as an individual and as part of a group under the same TIN. In this instance, the clinician will be evaluated across all 4 MIPS performance categories on their individual performance and on the group's performance, with a final score calculated for each evaluation. The clinician will receive a payment adjustment based on the higher of the two scores.

MIPS Eligibility Review Periods

To determine your eligibility for MIPS in 2019, CMS reviews Medicare Part B claims data and PECOS data at two points in time:

- First review: Completed in February 2019; examines claims from October 1, 2017 through September 30, 2018 and PECOS data.
- Second review: To be completed in late 2019; will examine claims data from October 1, 2018 through September 30, 2019 and PECOS data. If you joined a new practice during this time period, your eligibility will be evaluated during the second review.

If you participate in MIPS in 2019 as:

Individual Clinicians

An individual:

- You submit measures and activities for the practice(s) (identified by TIN) in which you're MIPS eligible.
- You'll be assessed across all 4 performance categories at the individual (TIN/NPI level).
- Your final score and MIPS payment adjustment will be based on your individual performance. (Voluntary submitters, which includes clinicians who do not exceed the low-volume threshold as individuals, will not receive a payment based on submitted data.)

Group

A group:

- You must meet the definition of a group at all times during the performance year and aggregate your performance data across the TIN (including clinicians who may not be eligible to participate in MIPS) in order to have your performance assessed as a group.
- You will be assessed as a group across all 4 MIPS performance categories, and the MIPS eligible clinicians in the group will receive the same payment adjustment based on the group's performance.

*A **group** is defined as a TIN with 2 or more eligible clinicians, including at least 1 MIPS eligible clinician, as identified by their NPIs who have reassigned their Medicare billing rights to the TIN.*

If you participate in MIPS in 2019 as:

Virtual Group

A virtual group:

- You must have elected to participate as a virtual group prior to the start of the 2019 performance year and must meet the definition of a virtual group at all times during the performance year.
- You will be assessed as a virtual group across all 4 MIPS performance categories and all the MIPS eligible clinicians in the virtual group (including Partial QPs) will receive the same payment adjustment based on the virtual group's performance. (Note, the election period for 2019 virtual groups is closed, but you can elect to participate as a virtual group in 2020. Review this toolkit to learn more.)

MIPS APM Entity Participant

A MIPS APM Entity participant:

- This means you've been identified on the QPP Participation Status tool as participating in a MIPS APM. You'll have modified participation requirements and will be scored according to the APM scoring standard.
- For the APM scoring standard, MIPS eligible clinicians are grouped and assessed through their collective participation in a MIPS APM Entity.

*A **virtual group** is defined as a combination of 2 or more TINs consisting of the following:*

- *Solo practitioners who are MIPS eligible (a solo practitioner is defined as the only clinician in a practice); and/or*
- *Groups that have 10 or fewer clinicians (at least 1 clinician within the group must be MIPS eligible). A group is considered to be an entire single TIN.*

TIP: If you practice in multiple groups during the performance year, you may participate in different ways for each group (TIN) under which you are MIPS eligible. If you're eligible for MIPS under multiple groups, you will receive a MIPS payment adjustment under each TIN/NPI combination based on the data submitted under that group.

MIPS PERFORMANCE CATEGORIES

Quality

The Quality performance category focuses on tools that help us measure health care processes, outcomes, and patient experiences of their care.

For the **2019 performance year**, the MIPS Quality performance category:

Has a maximum score of 60-80 points (depending on collection type)

AND

Accounts for 45% of your MIPS Final Score

To meet Quality performance category requirements, you need to:

Submit data for at least 6 quality measures for the 12-month performance period

AND

Include at least 1 outcome measure, or a high priority measure if an outcome measure isn't available, as 1 of the 6 measures

You may also select specialty-specific set of measures (e.g., cardiology, dentistry, emergency medicine, general surgery). In doing so, you must submit data on at least 6 measures within that set. If the specialty measure set has fewer than 6 measures, you need to submit all measures within that specialty set.

If you are registered to submit data through the CMS Web Interface, your group or virtual group will need to submit data for all 10 CMS Web Interface measures.

If you are participating in a MIPS APM this category is weighted at 50% of your MIPS Final Score under the APM scoring Standard. Please note that the Quality performance category requirements differ by model.

How to Choose Quality Measures

If you're participating in MIPS in 2019, you can choose from:

- **Quality Measures** — **More than 250 Quality measures** for the 2019 performance year
- **QCDR Measures** — **Qualified Clinical Data Registry (QCDR) measures developed by QCDRs** (outside of the MIPS measure set, if you choose to report quality data through a QCDR)
- **Quality Measures required by an APM** — **Quality measures required by an APM**, if you're in a MIPS APM
- **CMS web Interface Measures** — **CMS Web Interface Measures** , if you're a group, virtual group, or MIPS APM reporting via the CMS Web Interface

TIP: *For an overview of the quality measures, including specialty measure sets, use the Explore Measures tool on the Quality Payment Program website.*

New in 2019: We will aggregate quality measures collected through multiple collection types for the 2019 performance period. If the same measure is collected via multiple collection types, the one with the greatest number of measure achievement points will be selected for scoring. However, CMS Web Interface measures cannot be scored with other collection types other than the CMS approved survey vendor measure for CAHPS for MIPS and/or administrative claims measures.

How to Submit Quality Measures

You can submit your 2019 Quality performance category measure data in the following ways:

Individuals

- QCDR Measures
- MIPS Clinical Quality Measures (MIPS CQMs) (formerly referred to as "Registry measures")
- Electronic Clinical Quality Measures (eCQMs)

Note for 2019: *If you submit eCQMs, you'll need to use CEHRT to collect the data. Your EHR technology will need to be certified to the 2015 edition by the last day of the Quality performance period "(December 31, 2019).*

Groups or Virtual Groups

- QCDR Measures
- MIPS Clinical Quality Measures (MIPS CQMs) (formerly referred to as "Registry measures")
- Electronic Clinical Quality Measures (eCQMs)
- NEW Medicare Part B Claims (only for small practices participating in MIPS)
- CMS Web Interface Measures — *only for registered groups or virtual groups with 25 or more clinicians and Medicare Shared Savings Program (SSP) ACOs reporting on behalf of MIPS eligible clinicians*
- CAHPS for MIPS Survey Measure — *only for registered groups or virtual groups who want to administer the Consumer Assessment for Healthcare Plans and Systems (CAHPS) for MIPS survey*

How to Submit Quality Measures *(continued)*

All-Cause Readmission Measure: Groups and virtual groups with 16 or more clinicians are automatically subject to the All-Cause Hospital Readmission Measure if they meet the case minimum of 200 patients for the measure. Please note that no data submission action is required; CMS calculates this measure using administrative claims. The All-Cause Hospital Readmission measure is not a part of the APM Scoring Standard and won't be calculated for groups participating in a Shared Savings Program ACO.

NOTE: MIPS eligible clinicians, groups, and virtual groups who don't have 6 applicable quality measures may qualify for reduced submission requirements when submitting quality measures via Medicare Part B claims (small practices only) or MIPS CQMs.

View the Quality Requirements web page and the 2019 MIPS Quality Performance Category Fact Sheet for more information on the Quality Performance Category, Quality measures, and supporting documentation.

Cost

The Cost performance category is an important part of MIPS. Although clinicians don't personally determine the price of individual services provided to Medicare beneficiaries, they can affect the amount and types of services that are provided to their patients. By better coordinating care and seeking to improve health outcomes by ensuring their patients receive the right services, clinicians play a meaningful role in delivering high quality care at a reasonable cost.

For the **2019 performance year**, the MIPS Cost performance category:

Has a maximum score of 100

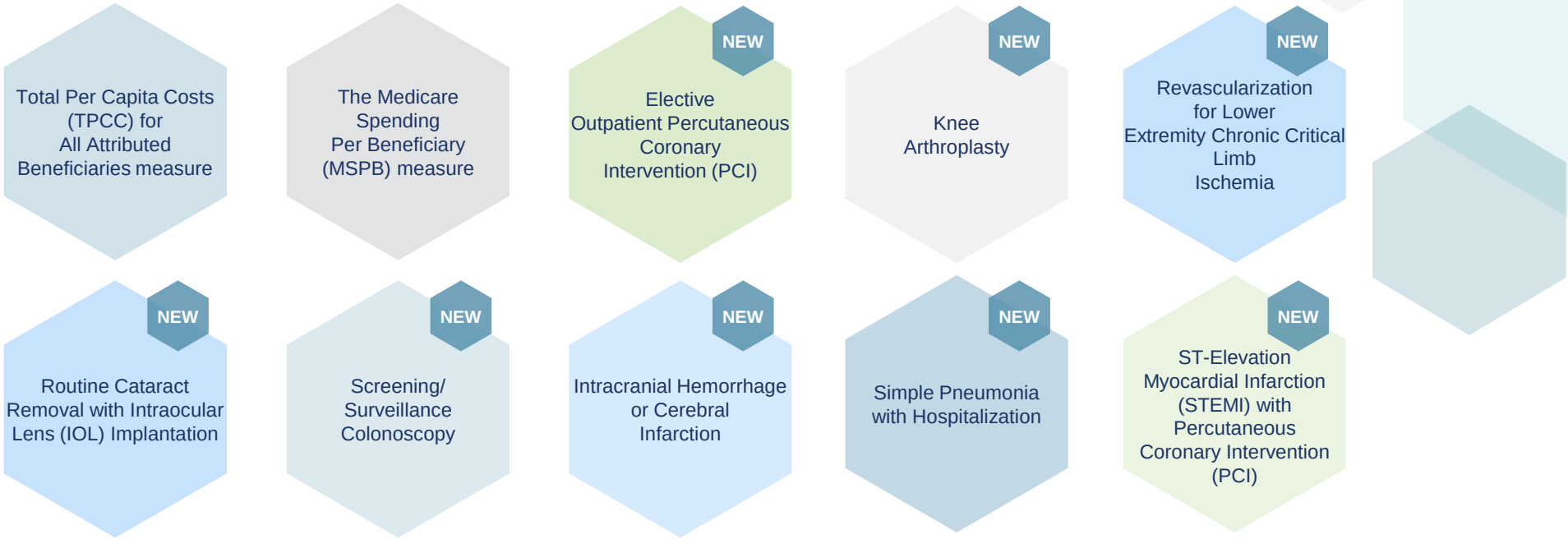
AND

Accounts for 15% of your MIPS Final Score

NOTE: CMS will use data from Medicare Part A and B claims—with dates of service from January 1, 2019 to December 31, 2019—to calculate your Cost performance category score. You do not need to submit any data or take any separate actions for this performance category. If you're in a MIPS APM, you won't be scored on the Cost performance category under the APM scoring standard.

Cost *(continued)*

In 2019, 10 cost measures are used to evaluate performance in the Cost performance category:



TIP: For a cost measure to be scored, an individual MIPS eligible clinician, group, or virtual group must have enough attributed cases to meet or exceed the case minimum for that cost measure. If only 1 measure can be scored, that measure's score will serve as the Cost performance category score. If, for example, 7 out of the 10 cost measures are scored, the Cost performance category score is the equally-weighted average of the 7 scored measures. If none of the 10 measures can be scored, the Cost performance category will count toward 0% of your MIPS final score, and we'll reweight your Quality performance category score to 60%.

For additional information, please refer to the 2019 Cost Measure Code Lists and the 2019 MIPS Cost Performance Category Fact Sheet.

Improvement Activities

The Improvement Activities performance category focuses on activities that relevant MIPS eligible clinician organizations and stakeholders have identified as improving clinical practice or care delivery and that the Secretary determines, when effectively executed, are likely to result in improved outcomes.

For the **2019 performance year**, the MIPS Improvement Activities performance category:

Has a maximum score of 40

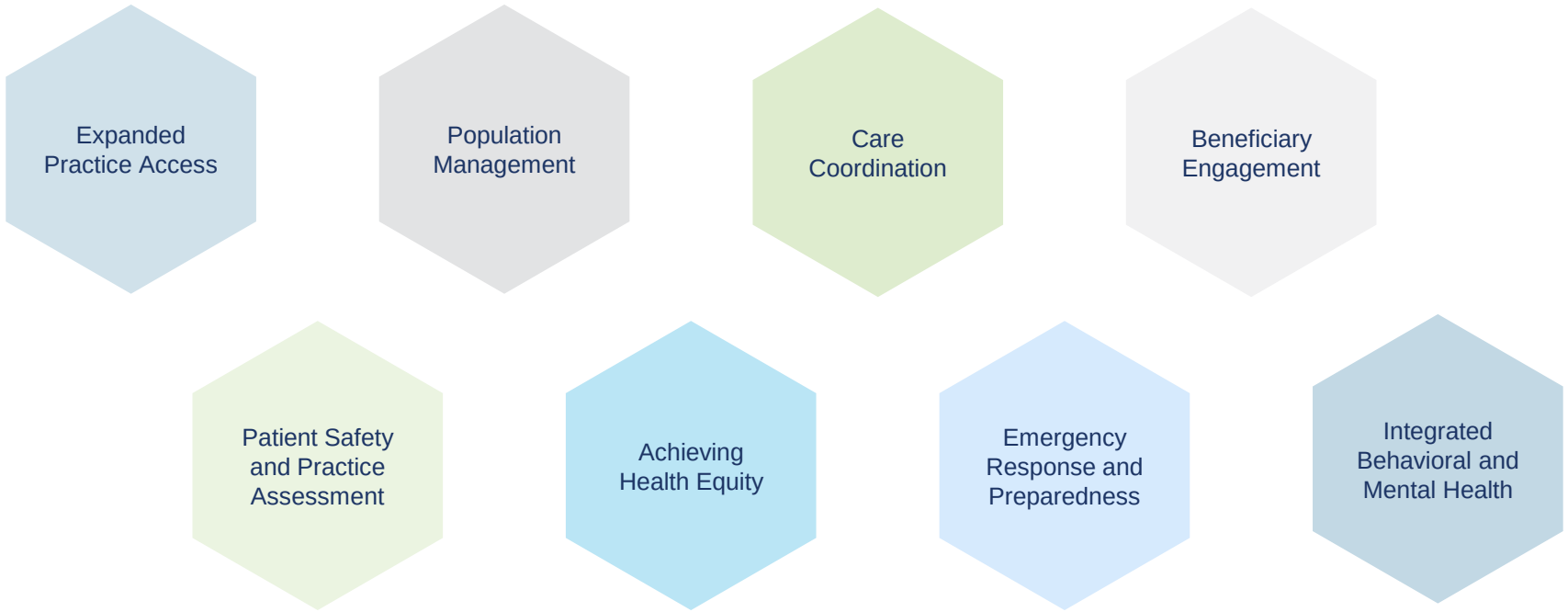
AND

Accounts for 15% of your MIPS Final Score

NOTE: MIPS eligible clinicians in a MIPS APM are scored under the APM scoring standard and are assigned an Improvement Activities performance category score, which will contribute to 20% of your MIPS Final Score. The performance category score will be at least 50 percent of the highest potential score and may be higher.

Choosing Improvement Activities

More than 100 MIPS improvement activities are divided into the following subcategories (categorized as either high-weighted or medium-weighted):



You don’t need to pick activities from each of the subcategories or from a certain number of subcategories; you should attest to the activities that you performed and are most meaningful to your practice.

Improvement Activities *(continued)*

For most MIPS eligible clinicians to successfully participate in the Improvement Activities performance category, you'll need to:

Report between 2 and 4 improvement activities, depending on the activities' weight

AND

Actively engage in each activity for at least a continuous 90-day period during the performance year

TIP: Activities do not have to be performed concurrently.

Special Statuses

You'll have fewer reporting requirements for the Improvement Activities performance category if you're a MIPS eligible clinician who qualifies for one of these **special statuses**:

You can earn full credit in the Improvement Activities performance category if you attest to 1 high-weighted

OR

2 medium-weighted activities if you're non-patient facing or in a small, rural, or HPSA-designated practice

For additional information, please refer to the full list of 2019 MIPS Improvement Activities and the Improvement Activities web page.

You can earn **full credit** for the Improvement Activities performance category if you are practicing in a certified patient-centered medical home, including a Medicaid Medical Home Model, Medical Home Model, or comparable specialty practice. A MIPS eligible clinician or group must attest to their status as a PCMH or comparable specialty practice in order to receive full credit.

Promoting Interoperability

The Promoting Interoperability performance category promotes patient engagement and the electronic exchange of health information using certified electronic health record technology (CEHRT).

For the **2019 performance year**, the MIPS Promoting Interoperability performance category:

Has a maximum score of 100

AND

Accounts for 25% of your MIPS Final Score

NOTE: MIPS eligible clinicians in a MIPS APM participate in MIPS through their MIPS APM Entity and are scored under the APM scoring standard. Under the APM scoring standard, this category is weighted at 30% of your MIPS Final Score.

Promoting Interoperability Measures

Beginning in 2019, there is a single set of Promoting Interoperability Objectives and Measures to report: 11 measures spread across 4 objectives. Clinicians must report the required measures from each of the 4 objectives, unless an exclusion is claimed. For 2019, we have moved away from the base, performance and bonus score methodology that was used for 2017 and 2018 to provide a simpler, more flexible, less burdensome structure.

Objectives	Measures
e-Prescribing	e-Prescribing
	Bonus (not required): Query of Prescription Drug Monitoring Program (PDMP) NEW
	Bonus (not required): Verify Opioid Treatment Agreement NEW
Provider to Patient Exchange	Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)
	Support Electronic Referral Loops by Receiving and Incorporating Health Information NEW
Public Health and Clinical Data Exchange (Must report 2 measures from this objective)	Immunization Registry Reporting
	Syndromic Surveillance Reporting
	Electronic Case Reporting
	Public Health Registry Reporting
	Clinical Data Registry Reporting

Promoting Interoperability *(continued)*

MIPS eligible clinicians must submit data collected using 2015 Edition CEHRT for the required measures from each of the 4 objective measures, unless an exclusion is claimed, for any continuous 90-day period in 2019.

In addition to submitting measures, clinicians must submit a "yes" to the following:

- Prevention of Information Blocking Attestations
- ONC Direct Review Attestation
- Security Risk Analysis

Each measure will be scored by multiplying the performance rate (calculated from the numerator and denominator you submit) by the available points for the measure. You can earn full points in the Public Health and Clinical Data Exchange objective by being actively engaged with 2 different registries (submitting "yes" for these measures) or by submitting "yes" for 1 measure and claiming an exclusion for 1 of the measures. You must submit a numerator of **at least 1 or a "yes"** to fulfill the required measures.

TIP: *Clinicians, groups, and virtual groups can earn 5 bonus points each for the submission of these optional measures:*

- *Query of Prescription Drug Monitoring (PDMP)*
- *Verify Opioid Treatment Agreement*

Promoting Interoperability Reweighting

Your Promoting Interoperability performance category may be reweighted to 0% if you meet one of the following criteria and apply for and receive a Promoting Interoperability hardship exception:

- MIPS eligible clinician in a small practice
- MIPS eligible clinician using decertified EHR technology
- Insufficient Internet
- Extreme and uncontrollable circumstances
- Lack of control over the availability of CEHRT

This performance category will automatically reweight to 0% for the following clinicians:

- Non-patient facing clinicians
- Hospital-based clinicians
- ASC-based clinicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinician types new to MIPS

(physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, and registered dieticians or nutrition professionals)

Promoting Interoperability Reweighting *(continued)*

Reminder, groups and virtual groups designated as non-patient facing are not automatically eligible to have their Promoting Interoperability performance category reweighted to 0 percent. To be designated as a non-patient facing group, 75 percent of the clinicians in the group must be non-patient facing. This does not fulfill the reweighting requirement for group reporting that, for the Promoting Interoperability performance category, 100 percent of the MIPS eligible clinicians in the group must qualify individually for reweighting.

For additional information, please refer to the:

- 2019 MIPS Promoting Interoperability Performance Category web page
- 2019 Promoting Interoperability Performance Category Fact Sheet
- 2019 Promoting Interoperability Measure Specifications.

NOTE: *If you're reporting as a group or virtual group, every MIPS eligible clinician in your group or virtual group must qualify for reweighting as an individual, by either automatic reweighting or through an approved hardship exception application, for the group or virtual group to be reweighted.*

MIPS PAYMENT ADJUSTMENT

How are Payment Adjustments Applied?

If you participate in MIPS in 2019, you'll receive a MIPS payment adjustment in 2021 based on your 2019 performance.

- If you submit data (and exceed the low-volume threshold or opt-in) as an individual, you'll receive a payment adjustment at the TIN/NPI level based on your individual performance.
- If you submit data as a group or virtual group, you'll be assessed as a group or virtual group across all 4 performance categories; the MIPS eligible clinicians in the group or virtual group will receive the same score and payment adjustment.
- If you submit data for the same practice as part of a group AND individually, CMS will take the higher of the 2 final scores and apply the MIPS payment adjustment associated with it.
  - Only 1 MIPS final score and MIPS payment adjustment is assigned to each unique TIN/NPI combination.
- If you participate in MIPS through an APM Entity, you will receive a MIPS final score and payment adjustment based on the APM Entity's combined performance. The score is calculated by weighting and combining Quality, Improvement Activities, and Promoting Interoperability scores. (Cost is not factored into the score in 2019.)
- If you participate in MIPS through two or more MIPS APMs, CMS will use the highest final score to calculate your MIPS payment adjustment.
  - There is one exception to this: If you are a dual participant in the Medicare Shared Savings Program and the Comprehensive Primary Care Plus (CPC+) Model, you will be only scored on your performance within the Shared Savings Program ACO for purposes of MIPS.
- If you participate in a MIPS APM and virtual group, CMS will base your final score and payment adjustment on your APM Entity's final score only.

How are Payment Adjustments Applied? *(continued)*

The MIPS payment adjustment percentage is applied to the Medicare Physician Fee Schedule (PFS) paid amount after calculating deductible and coinsurance but before sequestration. Payment adjustments are applied to payments for Medicare Part B covered professional services payable under the PFS; they will not be applied to Part B items and services furnished outside of the PFS.

The PFS Look-Up Tool provides information on services covered by the PFS, including fee schedule status indicators. For definitions of these procedure status indicator codes (or "PROC STAT" codes) please see page 9 of the document titled "PF19PA.pdf" in the PFS National Payment Amount File.

NOTE: The 2021 MIPS payment adjustment is applied only to Medicare Part B claims that are billed and paid on an assignment-related basis. When non-participating clinicians choose not to accept assignment for a claim, Medicare makes payment directly to the beneficiary, and the clinician collects payment from the beneficiary. In this circumstance, the MIPS payment adjustment does not impact this clinician. Non-participating clinicians who accept assignment for a claim accept the Medicare-allowed charge amount (PFS amount) as payment in full for the Part B-covered services provided to beneficiaries. The beneficiary's liability is limited to any applicable deductible plus any applicable coinsurance (typically 20 percent). In this situation, the MIPS payment adjustment would be applied to the payments for covered professional services billed on the claim.

RESOURCES, GLOSSARY, AND VERSION HISTORY

Quality Payment PROGRAM

You can find more resources at these links:

General:

2019 MIPS Quick Start Guide

2019 MIPS Participation and Eligibility Fact Sheet

2019 QPP Final Rule Executive Summary

2019 QPP Final Rule Overview Fact Sheet

Quality:

2019 Quality Requirements

2019 Quality Performance Category Fact Sheet

2019 Quality Measure Benchmarks

2019 Cross-Cutting Quality Measures

2019 Clinical Quality Measure Specifications and Supporting Documents

2019 Medicare Part B Claims Measures Specifications and Supporting Documents

Promoting Interoperability:

2019 Promoting Interoperability Requirements

2019 Promoting Interoperability Performance Category Fact Sheet

2019 Promoting Interoperability Measure Specifications

2019 Promoting Interoperability Information Blocking Factsheet

Improvement Activities:

2019 Improvement Activities Requirements

2019 Improvement Activities Performance Category Fact Sheet

2019 Improvement Activities Inventory

Cost:

2019 Cost Requirements

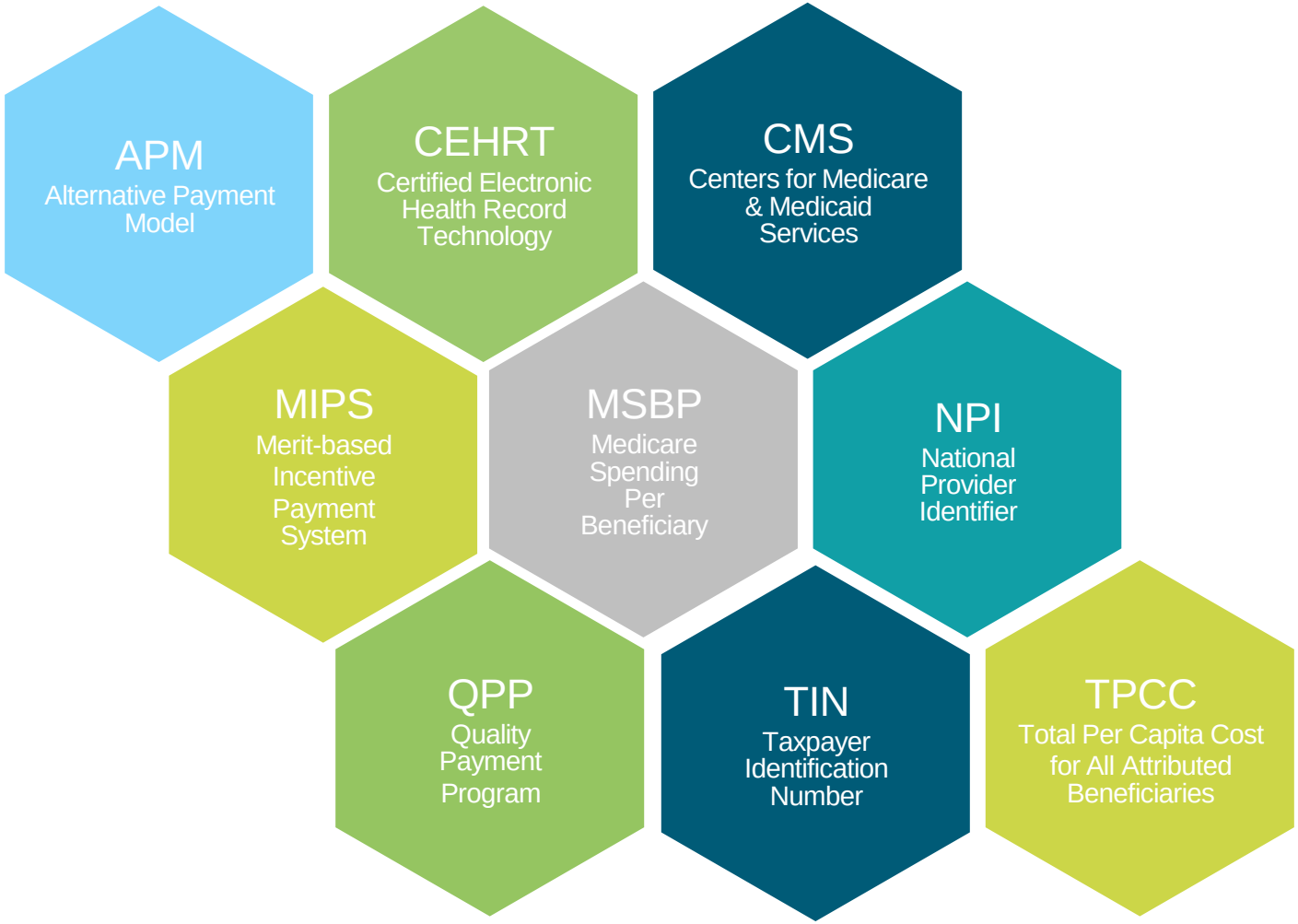
2019 Cost Performance Category Fact Sheet

2019 Cost Measure Code Lists

2019 Cost Measure Information Forms

Resources, Glossary, and Version History

Glossary



Resources, Glossary, and Version History

Version History

Date	Description
4/27/2020	p. 2 – Added disclaimer language regarding changes to 2019 MIPS in response to COVID-19.
2/20/2020	p. 32 – Updated Quality performance category maximum score to reflect updates to CMS Web Interface Measures PREV-10 and PREV-12 that have been reclassified as pay-for-reporting. This change affects the maximum number of points that can be earned by groups and virtual groups. (60 points for CMS Web Interface measures alone, 70 points if also scored on either the readmission measure OR CAHPS for MIPS measure, 80 points if also scored on both the readmission measure AND the CAHPS for MIPS measure.
1/30/2020	• p. 34 – Removed the Revascularization for Lower Extremity Chronic Critical Limb Ischemia measure from the list of ways to submit 2019 Quality performance category data; replaced with the CAHPS for MIPS Survey Measure. • p. 39 – Revised the improvement activities subcategories to remove Registered Dietitians or Nutritional Professionals as well as Participation in an APM, fixed Expanded Practice Access, and added Emergency Response and Preparedness.
9/16/2019	p. 19 – Updated based on CMS clarification that nonpatient facing groups do qualify for automatic reweighting of the Promoting Interoperability performance category in the 2019 performance period.
8/9/2019	Original Posting